

**White River Rural Health Center, Inc.**  
**PAYMENT VERIFICATION FORM**

**Request for Discounted Services**

I state that my annual family/individual income is \_\_\_\_\_ and the number of people in my family is \_\_\_\_\_. I understand that I must bring proof of income (one month's check stubs, last year's tax return, or an earnings statement from my employer *(must include name, address, date, signature of employer)*). If I fail to bring this information within 30 days or my next office visit (whichever occurs last), I understand that I will be responsible for 100% of the charges for services. When verification is provided, my eligibility for the sliding fee will be evaluated and any applicable discounts will be applied to future services.

I state that I am currently unemployed. I do not receive social security checks, welfare checks, V.A. checks, food stamps, child support, retirement or pension checks. I have no income at this time.

*"I understand that any charges not covered by the discounted services program or co-pays for such services I agree to pay and are my responsibility."*

\_\_\_\_\_  
*Patient signature* *Date*

\_\_\_\_\_  
*% Sliding Fee* *Date*

**Insurance Information**

Medicare # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Dental Insurance Co. \_\_\_\_\_

"I agree that White River Rural Health Center, Inc. will bill my insurance company or Medicare on my behalf for services received. I further agree that I am responsible for any charges not paid or denied by my insurance company. "

\_\_\_\_\_  
*Patient signature* *Date*

I have uninsured children. I understand that in the event my child(ren) qualifies for Medicaid or ARKIDS, I will be expected to complete the application process for one of these programs. Failure to do so will result in ineligibility for reduced payment services at White River Rural Health Center, Inc.

I do not have uninsured children.

\_\_\_\_\_  
*Patient Signature* *Date*